Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
P O BOX 24809
HOUSTON TX 77029

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4375-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached are copies of the original submissions along with the fax confirmations that the carrier received these submissions. Clearly the filing time limit was met."

Amount in Dispute: $55.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted a bill for code 95833FC, service date 7/28/10, to Texas Mutual on 8/30/10. Texas Mutual declined to issue payment as the code was inconsistent with the modifier…The requestor submitted a request for reconsideration of the initial denial of payment where it was received by Texas Mutual on 6/27/11…DWC Rule 133.250(b) states, 'The health care provider shall submit the request for reconsideration no later than eleven months from the date of service' Eleven months from 7/28/10 is 6/28/10. Thus, no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2010	CPT Code 95833-FC	$55.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.250 sets out the procedures for health care providers to submit workers' compensation reconsideration for payment of medical bills.
3. 28 Texas Administrative Code §133.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 7, 2010
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.

   Explanation of benefits dated July 13, 2011
   - CAC-138 – APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.
   - 879 – RULE133.250(B) – HEALTH CARE PROVIDER SHALL SUBMIT THE REQUEST FOR RE CONSIDERATION NO LATER THAN 11 MONTHS FROM THE DATE OF SERVICE.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

Issues

1. Was the dispute filed in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor bill CPT code 95833 with an appropriate modifier?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(A) states in pertinent part, that, "The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)." 28 Texas Administrative Code §133.states in pertinent part, that, "The health care provider shall submit the request for reconsideration no later than eleven months from the date of service." The requestor submitted their request for reconsideration of the initial denial to the respondent on June 22, 2011 and was received by the respondent via facsimile confirmation on June 27, 2011. The Division finds that the requestor submitted their request for reconsideration of the initial denial to the respondent later than eleven months from the date of service. The requestor did not meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(A).
2. Modifier FC is the appropriate modifier for CPT code 97750 only. 28 Texas Administrative Code §134.204(g) states, in pertinent part, that "FCEs shall be billed using CPT Code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title." The Division finds the requestor inappropriately billed the disputed CPT code 95883 using modifier FC.
3. The Division concludes that the requestor's request did not meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(A) and that the requestor inappropriately billed the disputed service. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 17, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.